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Covid Vaccines Damage All Hearts, Study Finds

Dylan Eleven
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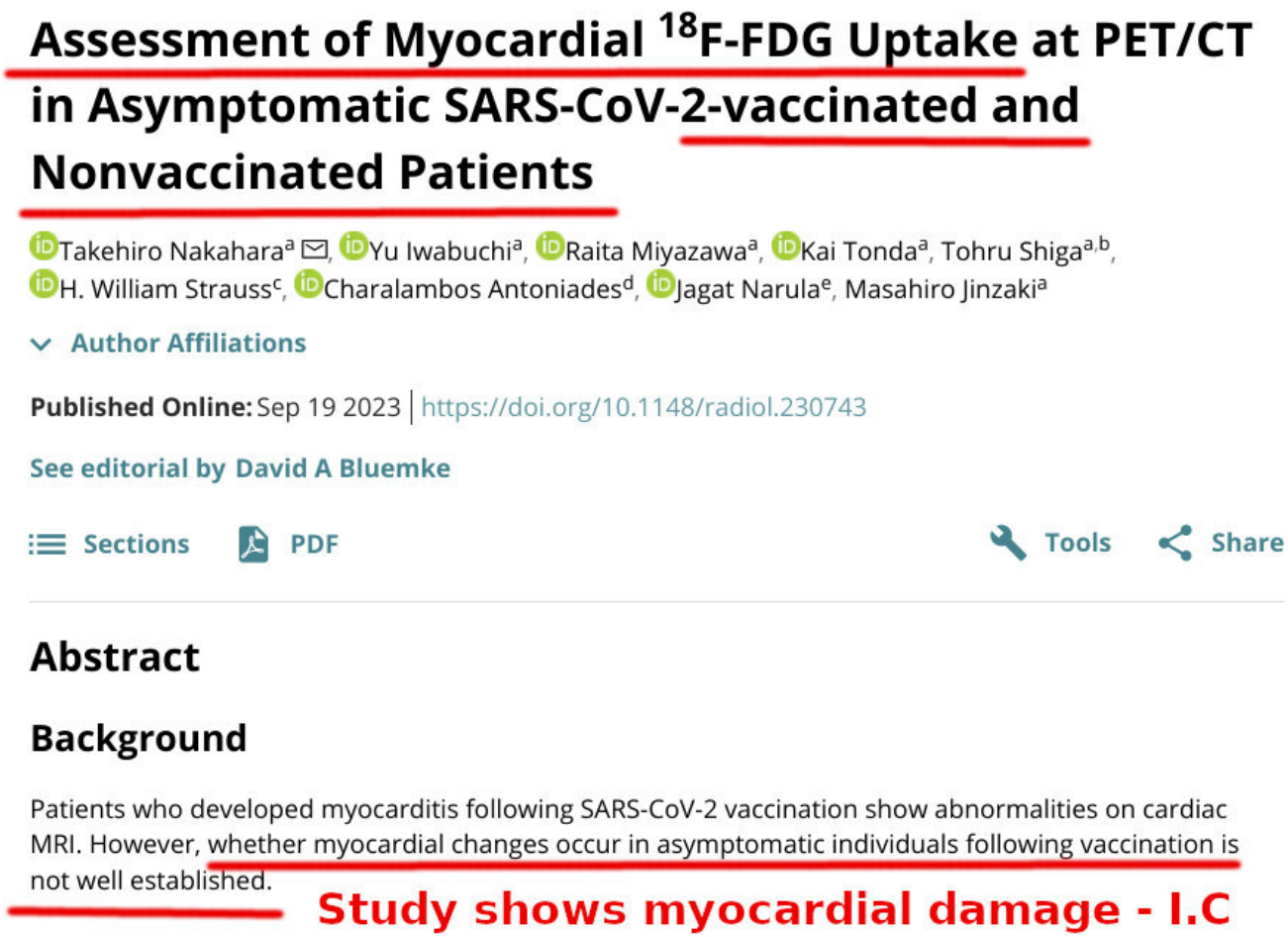
Igor Chudov | DailySceptic.org

A new scientific study by Nakahara *et al.* tested Covid-vaccinated people to see if they have “silent” changes in heart muscle function that standard radiology tests could detect. The study shows very unsettling results.

Nakahara et al 2023 assessment of myocardial 18f fdg uptake at pet ct in asymptomatic sars cov 2 vaccinated and
nakahara-et-al-2023-assessment-of-myocardial-18f-fdg-uptake-at-pet-ct-in-asymptomatic-sars-cov-2-vaccinated-and.pdf • 19 MB



Assessment of Myocardial ^{18}F-FDG Uptake at PET/CT in Asymptomatic SARS-CoV-2-vaccinated and Nonvaccinated Patients

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See editorial by David A Bluemke

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Abstract

Background

Patients who developed myocarditis following SARS-CoV-2 vaccination show abnormalities on cardiac MRI. However, whether myocardial changes occur in asymptomatic individuals following vaccination is not well established.

Study shows myocardial damage - I.C

Scientists measured myocardial ^{18}Fluorine-fluorodeoxyglucose (^{18}F-FDG) uptake. F-FDG has molecular similarity to glucose. However, ^{18}F-FDG does not metabolise like glucose. Therefore, PET scans could detect it, and its presence shows the heart muscle's abnormally high demand for glucose, indicative of abnormal cardiac function. More about it here.

> Conclusions: Focal myocardial ^{18}F-FDG uptake seen on oncologic PET/CT indicates a *significantly increased risk for multiple myocardial abnormalities.*

Indeed, this is what the Nakahara study finds (emphasis added, here and below):

> ***Results***
>
> *The study included 303 nonvaccinated patients (mean age, 52.9 years; 157*

> *females) and 700 vaccinated patients (mean age, 56.8 years; 344 females). Vaccinated patients had overall higher myocardial FDG uptake compared to nonvaccinated patients (median SUVmax, 4.8 vs median SUVmax, 3.3 ; P < .0001). Myocardial SUVmax was higher in vaccinated patients regardless of sex (median range, 4.7-4.9) or patient age (median range, 4.7-5.6) compared to corresponding nonvaccinated groups (sex median range, 3.2-3.9; age median range, 3.3-3.3; P range, <.001-.015). Furthermore, increased myocardial FDG uptake was observed in patients imaged 1-30, 31-60, 61-120, and 121-180 days after their second vaccination (median SUVmax range, 4.6-5.1) and increased ipsilateral axillary uptake was observed in patients imaged 1-30, 31-60, 61-120 days after their second vaccination (median SUVmax range, 1.5-2.0) compared to the nonvaccinated patients (P range, <.001-<.001).*

This was not supposed to happen! The Covid vaccine is not supposed to affect the heart in any way. It was promised to ‘stay in the arm’.

The explosive findings of the study are discussed in the editorial that the Editor of the magazine, Dr. Bluemke, felt obliged to publish.

COVID-19 Vaccines and Myocardial Injury

David A Bluemke

Author Affiliations

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See also the article by Nakahara et al in this issue.

Dr Bluemke is Professor of Radiology at the University of Wisconsin School of Medicine and Public Health. Dr Bluemke is the Editor Emeritus of the journal Radiology. Dr Bluemke's research has focused on early detection and diagnosis of cardiovascular disease using noninvasive imaging techniques, particularly

Dr. Bluemke's editorial is somewhat apologetic, and he gives *faint praise* for Covid vaccines.

> The development of messenger RNA (mRNA) COVID-19 vaccines is a remarkable biotech story. While traditional vaccines took 5-10 years to develop, *the COVID-19 vaccines took less than a year. By comparison, the fastest conventional vaccine previously developed was the mumps vaccine, on a timescale of four years.*

Dr. Bluemke also does not mince words. He explains that the findings are not due to chance:

> The main results: *asymptomatic* patients vaccinated for COVID-19 before PET had about 40% greater radiotracer activity in the myocardium than unvaccinated individuals. *The P value was low, less than .0001. This translates to only one time out of 10,000 that these results would occur by chance.*

The editorial states that there is no rational way to ignore and explain away the negative findings of myocardial inflammation by Takahara *et al.*:

> Vaccine manufacturers are aware of the adverse effects of mRNA vaccines. These adverse effects lead to vaccine hesitancy. The study results by *Nakahara* et al. *suggest that mild asymptomatic myocardial inflammation could be more common than we ever expected.* This in turn would support a hypothesis of more severe systemic inflammation related to mRNA vaccination in some patients who present with *symptoma-c* myocarditis.

Dr. Bluemke calls for further research into this:

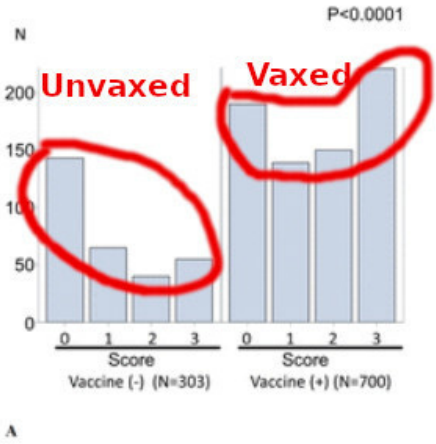
> The investigators understood their first result was only the starting point. They next performed extensive 'sensitivity analyses' – i.e., looking at the same data from multiple different directions. What if we account for age differences between groups, and the number of vaccinations? *If mRNA vaccinations do cause asymptomatic myocardial inflammation, wouldn't the effect be more likely shortly after vaccination, rather than six months later?* Many of us who had COVID-19

> vaccines had flu-like symptoms immediately after vaccination – *perhaps those of us with common flu-like reactions would have more myocardial inflammation as well?* Could trained readers see the differences visually? Or were the differences seen only after placing regions of interest on the heart that could be accidentally mispositioned? The list goes on. *Great researchers are also sceptics – they need to prove the results to themselves.*

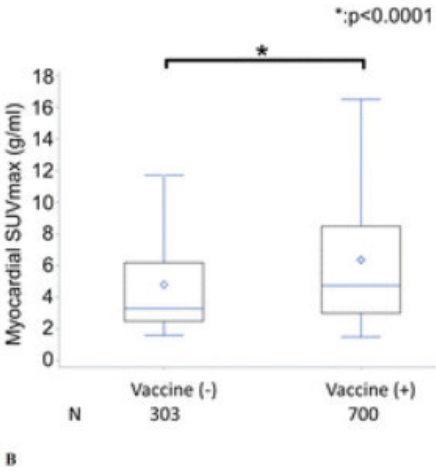
Was the increase in myocardial inflammation due to a few unlucky patients driving high averages, with most people remaining unaffected?

Unfortunately, that is not the case: all quartiles were affected deleteriously, as this image shows:

Compared to nonvaccinated patients, vaccinated patients had a higher myocardial FDG uptake visual score (median, 2 [IQR: 0-3] vs 1 [IQR: 0-2], *P* <.001) (Fig 3A) and SUVmax (median, 4.8 [IQR:3.0-8.5] vs 3.3 [IQR: 2.5-6.2], *P* <.001) (Fig 3B), which remained after age-adjustment for both measures (*P* <.001). In patients without cancer, vaccinated 372 individuals also showed a higher median myocardial FDG uptake visual score (median, 2 [IQR:0-3]) and SUVmax (median, 4.8 [IQR: 3.2-8.3]) compared to 150 nonvaccinated individuals (median visual score, 1 [IQR: 0-2]; median SUVmax, 3.3 [IQR: 2.6-6.3]; *P* < .001 for both).



F-FDG uptake higher in ALL vaccinated quartiles - so the effect exists in most patients



Is there a *dose-response relationship*, providing further proof of causality? Can we see if the higher-dose Moderna vaccine causes *more* heart problems than the lower-dose Pfizer vaccine?

Recall that studies of other topics, such as pregnancy outcomes, show a 42% greater miscarriage rate and 93% greater infant death rate for Moderna (higher dose vaccine) compared to Pfizer.

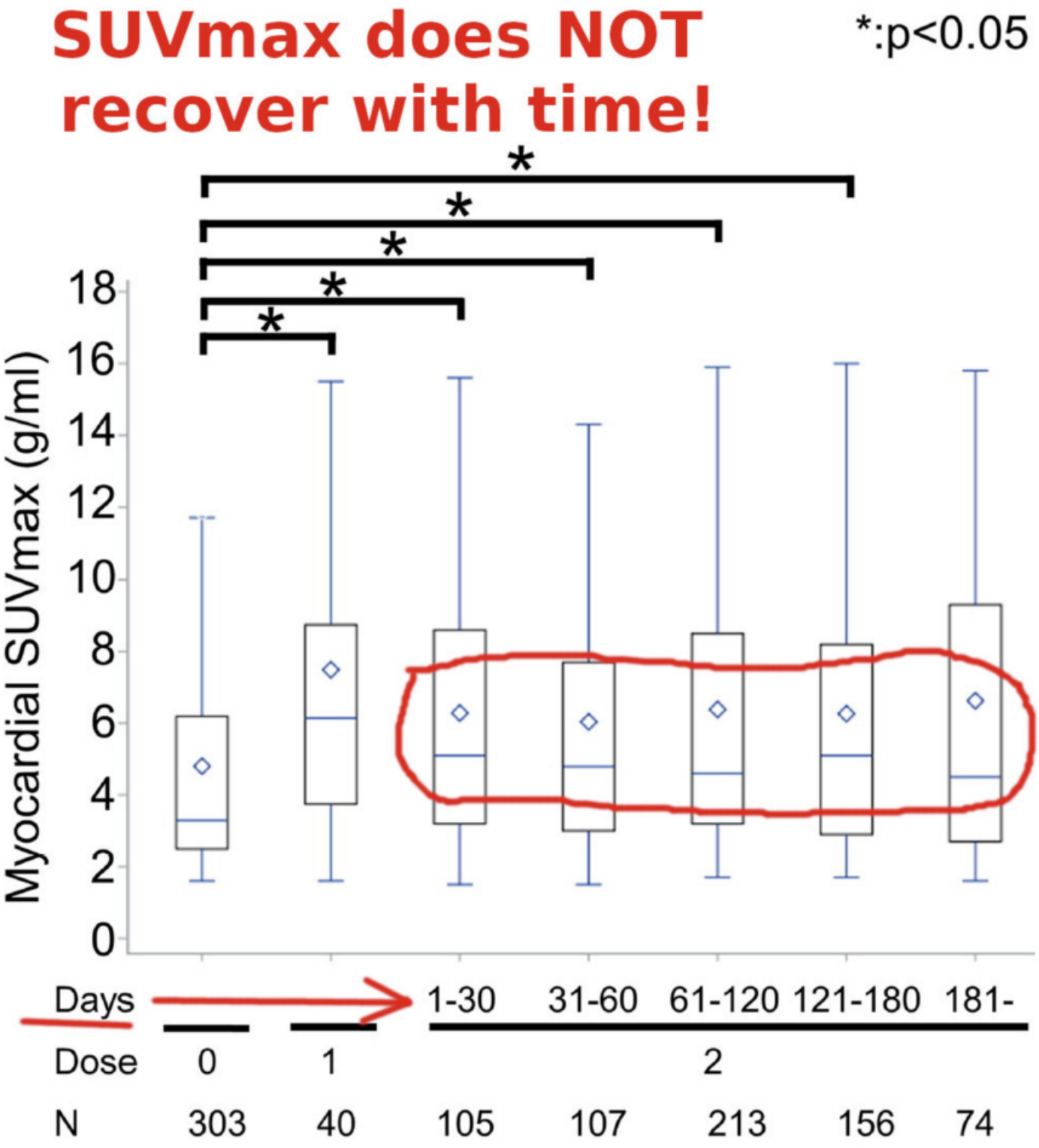
What about the Nakahara study we are discussing? It shows a weaker but similar pattern of greater response due to Moderna:

Myocardial FDG Uptake in Patients Stratified by type of vaccine

Of the vaccinated patients, the majority (543/700 [77.6%]) received BNT162b2 mRNA (Pfizer-BioNTech), followed by mRNA-1273 (Moderna, 147/700 [21%]). Patients who received ChAdOx1 nCoV-19 (AstraZeneca) (1/700 [0.1%]) or miscellaneous types (9/700 [1.3%]) were excluded from the following analysis due to the small sample size. As compared to the unvaccinated group (median myocardial SUVmax, 3.3 [IQR: 2.5-6.2]), the myocardial SUVmax was higher in both vaccinated groups (p <.001-<.001), with no difference in FDG uptake observed between BNT162b2 mRNA (median SUVmax, 4.7 [IQR: 2.9-8.4]) and mRNA-1273 (median SUVmax, 5.1 [IQR: 3.4-8.7]; *P* = .39) vaccine types. Axillary SUVmax for both BNT162b2 mRNA (median, 1.4 [IQR: 1.1-1.8]) and mRNA-1273 (median, 1.5 [IQR: 1.1-2.0]) were also higher than the nonvaccinated group (median, 1.2 [IQR: 1.0-1.4]; *P* <.001-<.001) (Fig S6).

The authors say there is “no difference” between Pfizer and Moderna. However, there *is* a difference. Pfizer-vaccinated patients’ SUVmax was 4.7, and Moderna-vaccinated patients (Moderna is a greater dose, remember) had a greater SUVmax of 5.1. The difference did not reach statistical significance, likely due to a small sample size.

Does the ill effect go away as time passes? Unfortunately, the scientists’ chart of SUVmax over time does not show complete recovery during 180 days, still above the unvaccinated level:



A test of cardiac function via F-FDG uptake, a standard radiological test, is something that careful scientists conducting Covid vaccine clinical trials could carry on with a few

hundred patients. Watchful vaccine safety agencies could demand such tests to be conducted to ensure the general public's safety. They chose not to do it, and their sponsors (Pfizer and Moderna) made much money selling unproven and untested Covid vaccines.

The vaccines, instead of stopping the pandemic, damaged the heart muscles of millions.

I hope that the vaccinated people will be able to ask for compensation for their damaged hearts.

The reality, sadly, is that the damage will most likely be ignored, and the vaccine billionaires will enjoy their newfound wealth while the hysterical Pfizer-sponsored press will be scaring us with new distractions.

Source: https://www.igor-chudov.com/p/covid-vaccines-damage-all-hearts

Original Article: https://davidicke.com/2023/10/03/covid-fake-vaccines-damage-all-hearts-study-finds/